



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Christopher Pulido, D.C.

Respondent Name

American Casualty Company of Reading, PA

MFDR Tracking Number

M4-17-1424-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

January 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: \$242.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is no dispute over the MAR amount for the provided services. At issue in this case is the fact that \$242.20 was withheld from the Requestor and paid directly to the IRS as Federal withholding tax. This information was provided to the Requestor with the issued payment in the reduced amount of \$622.80."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2016	Designated Doctor Examination	\$242.20	\$227.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services performed from March 1, 2008 until September 1, 2016.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - Z469 – Procedure is reimbursable when requested by carrier or self-insured employer.

- Z559 – Reimbursement has paid in accordance to The Texas Division of Workers Compensation Rules, Chapter 129 rule 129.5(a)-(j).
- Payment reduced citing: “FED TAX WITHHELD”

Issues

1. Did the carrier issue an explanation of benefits in accordance with 28 Texas Administrative Code §133.240?
2. Is Christopher Pulido, D.C. entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §133.240 states, in relevant part:
 - (e) ... The insurance carrier shall send an explanation of benefits in accordance with subsection (f) of this section if the insurance carrier submits the explanation of benefits in paper form. The explanation of benefits shall be sent to:
 - (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill ...
 - (f) The paper form of an explanation of benefits under subsection (e) of this section ... shall include the following elements: ...
 - (17)health care service information for **each billed health care service** [emphasis added], to include:
 - ...
 - (F) amount paid;
 - (G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;
 - (H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph...

Review of the submitted explanation of benefits submitted by American Casualty Company of Reading, PA (American Casualty) finds that the insurance company failed to include adjustment reason codes or explanations for a reduction of payment for each billed service in question. The division concludes that American Casualty did not issue an explanation of benefits in accordance with 28 Texas Administrative Code §133.240.

2. Dr. Pulido is seeking an additional reimbursement of \$242.20 for a designated doctor examination performed on August 6, 2016, represented by procedure codes 99456-W5-NM, 99456-W8-RE, and 99080-73.

28 Texas Administrative Code §134.204(i)(1) states, in relevant part:

Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and **shall be billed and reimbursed** as follows [emphasis added]: ...

- (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier “W5” is the first modifier to be applied when performed by a designated doctor ...
- (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W8”

Per 28 Texas Administrative Code §134.204(j)(2)(A):

If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier “NM” shall be added.

Paragraph (3) states, “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation supports that Dr. Pulido performed an evaluation of maximum medical improvement (MMI) and found that the injured employee was not at MMI. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.

28 Texas Administrative Code §134.204(k) states, in relevant part:

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports...

The submitted documentation indicates that Dr. Pulido performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is \$500.00.

Per 28 Texas Administrative Code §134.204(l), "The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title ..." Therefore, the filing of the DWC-073 is not separately payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204(i).

The total MAR for the services in question is \$850.00. American Casualty reimbursed Dr. Pulido \$622.80. An additional reimbursement of \$227.20 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$227.20.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$227.20, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	Laurie Garnes	July 7, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.